CHCS Center for Health Care Strategies, Inc.

Detailed Matrix of Select State Behavioral Health Systems

The following matrix outlines key aspects of 7 state behavioral Health models. It is organized according to whether a state has a carve-in model, carve-out model or is developing a population carve-out model.

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges

Carve In	**KY**[1]	Three statewide MCOs (effective as of October 2011).	• MCOs coordinate all PH, BH, pharmacy, vision and dental (can subcontract). Members in nursing homes and waivers will not transition to managed care.	• Risk Based Contract.
				• Capitated payments, CDPS used to risk adjust rates.
				• Administrative costs cannot exceed 10% of the total managed care contract cost.
				• BH dollars are not "protected"
					• Require NCQA accreditation.
					• Report annually on HEDIS measures; contractor and department will select a subset of HEDIS reported measures on which department will evaluate performance and determine whether contractor is required to implement a performance improvement initiative.
					• Conduct CAHPS survey.
					• Monitor and evaluate on an ongoing basis through QA/PI and integrate BH indicators into its QA/PI program.
					• Required to do performance improvement projects (1 PH, 1BH).
					• Required to report on trends in utilization, e.g.:
					  ○ Inpatient hospital admissions and days/ thousand member months
					  ○ Outpatient hospital visits per thousand member months
					  ○ % ER visits resulting in admissions
						• As noted in the contract, state is concerned regarding use of evidence based practices for behavioral health services. Primary focus will be on further development/ expansion of supported housing, supported employment, development of peer support and recovery models of care.

[1] Information obtained from Kentucky Medicaid managed care contract (Kentucky Spirit Health Plan), effective October 1, 2011, available at: http://finance.ky.gov/services/eprocurement/Documents/Medicaid%20Managed%20Care%20Contracts/FinalKentuckySpiritMCOContractwithsignature.pdf

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					○ Ambulatory surgery/ procedures per thousand member months ○ Hospital readmissions per thousand member months ○ Average visit per provider by major type ○ Mental hospital admits per thousand ○ Prescriptions dispensed by major drug class per thousand member months • Contractor must require providers to follow up after hospitalization for behavioral health services: ○ Outpatient treatment must occur within 14 days of day of discharge; ○ Behavioral health providers must contact members who missed appointments within 24 hours to reschedule	
	TN[2]	Regional MCOs.	MCOs cover and integrate PH, BH and LTC benefits for all beneficiaries statewide. BH benefits include: • Psychiatric inpatient. • 24-hour psychiatric residential treatment. • Outpatient mental health.	• Full risk contract. • MCOs can subcontract, but stringent provisions included in contract regarding co-location of staff and key personnel at the administrative level. • Capitation rate for each enrollee based on rate category, health plan risk	• Required to do two clinical performance improvement projects (1 in area of BH). • Require NCQA accreditation. • Report on HEDIS measures designated by NCQA as relevant to Medicaid, CAHPS surveys. • Provide specialized service reports: psychiatric hospital readmission, post discharge service report,	• TN moved to a carve-in model to avoid MCO/BHO disputes regarding who was responsible for a given claim. • Carve-in model allowed for "organic" development of integrated clinical models at a local level. • Carve-in model requires

[2] Information obtained from direct communication with state officials and Tennessee Medicaid (TENNCARE) managed care contract, updated January 1, 2012, available at: http://www.tn.gov/tenncare/pro-mcos.html.

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
			• Inpatient, residential and outpatient substance abuse benefits. • Mental health case management. • Psychiatric rehab services. • BH crisis services.	assessment scores, health status based on ACG case mix system • MCOs all include BH conditions in risk stratification. • To ensure contractor compliance with all requirements in contract, there is a 10% withhold of monthly capitation payment for the first 6 months following start date of operation, and for a 6 month period following receipt of a notice of deficiency. If there are no deficiencies for a 6 month period, withhold is reduced to 5% of monthly cap payment. Once reduced to 5%, will be further reduced to 2.5% if there are no deficiencies in a 6 month period. • TENNCARE will make pay for performance quality incentive payments to the contractor. Contractor is eligible for $.03 PMPM for significant improvement (defined using NCQA's minimum effect size change methodology) on PH	behavioral health crisis response report. • BH HEDIS Measures used to determine pay for performance: o Antidepressant medication management o Follow-up care for children prescribed ADHD medication o Follow-up after hospitalization for mental illness • 23 performance standards with associated liquidated damage for failure to meet standards. BH related measures include: o Length of time between psychiatric hospital discharge and first mental health service that qualifies as post-discharge (must not exceed 7 days) o Not more than 10% of members discharged from inpatient/residential facility (psychiatric hospital) readmitted within 7 days o Not more than 15% of members discharged from inpatient/residential facility (psychiatric hospital) readmitted within 30 days	close collaboration across Medicaid/MH agencies.

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
				HEDIS measures and BH HEDIS measures. See "Performance Measures" column for specific measures. • BH dollars are not "protected"		
Carve Out	**CT**[3]	Statewide ASO for Medicaid FFS population.	• Responsible for clinical-, utilization-, ICM-, quality- and data management. • Required to enhance communication and coordination within the BH system, assess network adequacy and improve overall service delivery. Core clinical services overseen by ASO: • Intermediate inpatient psychiatric care • Acute psychiatric hospitalization • Partial hospitalization • Intensive outpatient • Outpatient • Medication evaluation/ management • Substance abuse/	• Department of Social Services (DSS) responsible for claims payments. • Profit (calculated as 7.5% of total administrative contract costs) withheld and paid only to the extent that the contractor meets performance targets.	• 7.5% of each quarterly payment withheld, paid in whole or in part based on success in meeting performance targets (each has a separate value). Performance targets tied to objectives such as: ○ Access ○ Quality ○ Overall child and adult community service to inpatient ratio ○ Overall expenditures. • Information regarding specific performance targets forthcoming. • In addition, specific performance standards set by department. Failure to meet performance standards will result in sanctions for each occurrence. Payment will be adjusted by a specific dollar amount set for each performance standard. Contractor must provide a corrective action plan. • Required to do 4 quality improvement initiatives per year, starting in year 2 of the contract	• Goals for the ASO include: improve quality of publicly funded BH care, promote recovery, and improve management of state resources and increase FFP for BH services.

[3] Information obtained from Connecticut Behavioral Health Recovery Plan RFP, June 30, 2010. Information about Connecticut Behavioral Health Partnership available at: http://www.ctbhp.com/

States	Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
		detoxification services • Psychological/ neuropsychological testing • Adult day treatment • Home based services for children • Home health agency services • Medication assisted treatment • Mental health group homes • Extended day treatment • Observation bed at acute care hospitals • Additional grant covered services (e.g. psychosocial rehab, ACT) for individuals with SPMI and/or substance abuse disorders not in purview of ASO, but ASO must work collaboratively with local mental health authorities (who deliver and manage services for SPMI population). ASO to provide data to LMHAs regarding utilization to improve coordination of care.			

States	Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
IA[4]	Statewide BHO.	Covered mental health services • Inpatient MH • Outpatient MH • Services through CMHCs • Service provided by licensed social worker for treatment of mental illness or SED; licensed psychologist for testing/evaluation • Crisis and emergency services • Mobile counseling • Targeted case management • ACT • Home Health Services • Services in state mental institutions for under 21 and over 65 • Medication management • Prescription medication is through FFS Covered substance abuse services • Outpatient treatment	• Full risk contract. • Braided funding: Medicaid, state only funds, block grant funds • Incentive payments (up to $1,000,000 per contract year) based on performance indicators. • Disincentives based on performance. • Reinvestment: 2.5% of monthly cap payment placed in interest bearing account and could be used to fund additional services (b3) or training and outreach activities (with state approval).	Performance indicators with incentives: • Mental Health Readmissions – rate of admission at 7, 30, 90 days • Community Tenure – average # of days between MH hospitalization per contract period shall not fall below 94 days • Integrated services and Supports – at least 18% of MH expenditures used for integrated services • ER utilization – less than or equal to 8.5 visits per 1,000 member months • Follow-up after hospitalization for mental illness – within 7 days for 90% of enrollees • Follow-up after hospitalization for substance abuse treatment – within 14 days for 60% of enrollees • Implementation of MH discharge plans – 94% implemented • Treatment of the dually diagnosed – 25% receive MH and SA treatment follow up within 7 days, 50% within 30 days • Network management – full implementation of provider profile reporting and network management requirements as in RFP. Performance indicators with disincentives • Consumer involvement – new enrollee information provided • Mental health discharge plan –	• Braided funding addresses the "patchwork" of funding from multiple agencies for BH services, but it is difficult to manage administratively.

[4] Information obtained from the Iowa Plan (Medicaid behavioral health managed care) contract (Magellan), January 1, 2010, available at: http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html, and from corresponding RFP (RFP Med 09-010).

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
			• Ambulatory detoxification • Intensive Outpatient • Partial hospitalization • Residential treatment and detoxification • Inpatient treatment and detoxification • Emergency services • Ambulance services for substance abuse conditions • Services part of substance abuse treatment (e.g. lodging, rehab counseling, diagnostic testing specific to substance abuse treatment, etc.) • Screening/evaluation		discharge plan on day of discharge for 90% of enrollees • Discharge to homeless or emergency shelter – shall not exceed 1% of MH inpatient discharge for under 18 • Follow-up on ER visits – within 3 days for 95% of enrollees • Participation in joint treatment planning conferences – at least 20/month, 450 per year • Follow-up after hospitalization for substance abuse treatment – within 30 days for 63% discharged from 24-hour substance abuse services • Substance abuse treatment discharge plan – discharge plan on day of discharge for 90% of enrollees • Claims payment • Appeal reviews • Grievance reviews • Network management • The state has some monitoring only performance indicators as well	

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NM[5]	Statewide BHO	Medicaid covered services for adults and children include: • Psychiatric inpatient hospital services at a psych unit in a general hospital • 23 hour observation • Inpatient professional services by a BH professional • Partial hospitalization • Hospital outpatient services • Outpatient behavioral health professional services (evaluation, testing, assessment, counseling and therapy) • Comprehensive community support services • Telehealth services • Pharmacy services • Intensive outpatient services for substance abuse and co-occuring disorders Medicaid adults -only services include: • Psychosocial rehab	• Braided funding: Medicaid; Children, Youth and Families Department; Department of Health; HSD/Behavioral health services division; New Mexico Corrections Department; New Mexico Aging and Long Term Services Department. • Full risk contract with capitated payment. • Reinvestment: 4.5% of total amount of the HSD managed care revenue applied toward value added services (services not included in the Medicaid benefit package) and community reinvestment. Community reinvestment used for collaborative approved projects that expand capacity of communities to deliver sustainable services. In addition, the statewide entity must make available $250,000 for community reinvestment on top of the 4.5%, which can be used	• Required to have a quality management/quality improvement program for continuous monitoring and evaluation; QM/QI policies and procedures must emphasize and promote prevention and care coordination. • Statewide entity must track performance measures, establish baseline and track changes over time. Failure to achieve performance targets may result in sanctions. The Collaborative will identify performance targets for which sanctions are applicable.	• Priorities include: to expand pilot projects and other needed services, improve communication with and services to tribal communities, improve communication with other state contractors (The Salud!, CoLTS, MCOs, SCI), and improve training and workforce development. • Same issues with braided funding as in IA example. • Integrating care with physical health side is a challenge. • Disputes over payments between physical health and behavioral health MCOs can be an issue.

[5] Information obtained from Optum Health wesite: https://www.optumhealthnewmexico.com/consumer/en/handbook/HB_welcome.jsp; and RFP for Medicaid managed care contract for FY 2010-2013, available at: http://www.bhc.state.nm.us/BHNews/RFPsStatewideEntity.html. To note, New Mexico is moving to a carve-in model.

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
			• ACT Medicaid child-only services include: • Psychiatric inpatient hospital services in a free standing psych hospital • Behavioral health outpatient services • Accredited and non-accredited residential treatment center services • Group home services • Treatment foster care • Day treatment services • Multi-systemic therapy • Behavioral management skills development services • Counseling, evaluation, therapy in a school based setting	to purchase any licenses associated with Addiction Severity Index – Multimedia Version.		
	NY[6]	Regional ASO.	• Responsible for population receiving behavioral health inpatient services on a Medicaid FFS basis. Duals are excluded.	ASO does not pay claims.	• Will develop and implement a quality assurance program • State will use claims data to monitor key system performance metrics. Additional metrics will be collected and provided by the ASO. Based on data from the ASO and Medicaid	• Key goal for NY is to increase quality and efficiency, and reduce Medicaid costs. Goal and purpose of ASO/BHO is to monitor behavioral health inpatient length of stay,

[6] Information obtained from New York RFP, June 24, 2011. To note, New York is moving from an ASO to BHO model in 2013; in NYC one entity will manage all behavioral and physical health benefits for the SMI population.

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
			• ASO must monitor, review and asses the use of BH inpatient care, monitor discharge planning activities and facilitate timely connection to post-discharge services, Enhanced activities for: (1) state-identified subsets that are disengaged from care; (2) individuals readmitted for inpatient care; (3) individuals who had multiple admissions for detoxification. Additional responsibilities including tracking SED children's outpatient utilization, provider profiling and facilitating cross system linkages.		claims, OMH and OASAS will analyze several domains of system performance, such as: ○ Access – expectation that access to appropriate BH services will be maintained as managed care strategies implemented ○ Engagement in treatment and continuity of care – expectation that individuals who have been hospitalized will be engaged in appropriate follow up services upon discharge ○ Inpatient length of stay – appropriate duration ○ Readmissions – expected to decrease ○ Acceptability – post-discharge individuals will be referred to services with providers that offer services which individuals find useful enough to come back a second time	reduce unnecessary BH inpatient hospital days and readmission rates, improve rates of engagement in outpatient and post discharge, test metrics of system performance, and profiling provider performance.
Pop. Carve Out	**AZ**[7]	Maricopa county.	• As of October 2013, RBHA will be responsible for managing all physical and behavioral health services for SMI	• Full risk contract. • AZ does not intend for any subcontracting. • Looking at payment model that includes incentives.	TBD	This model is still emerging, thus conclusions cannot yet be drawn. Potential benefits include: • Integration of services creates alignment of

[7] Information obtained from direct communication with state officials and state website: http://www.azdhs.gov/diro/integrated/rbha/index.htm

States		Geographic Area	Scope of Services	Financial Model	Performance Measures	Goals/Challenges
			population, including dual eligibles. • Intent is for RBHA to also be a Medicare Advantage SNP, and to be closely linked to provider-based SMI health homes.			financial incentives across physical and behavioral health systems. • Access to full range of data allows for effective care management. • Leveraging specialty knowledge of the behavioral health system to serve a population that it knows best. • Beneficiaries have seamless access to benefits and services. Potential challenges include: • Identifying plans with sufficient capacity across physical and behavioral health to adequately and effectively deliver services • Determining whether oversight should sit within Medicaid or the mental health agency counterparts.